would seem to be indicated and might improve the poor prognosis of severe copper intoxication complicated by acute renal failure.

DAVID E C COLE

Department of Pediatrics,
University of British Columbia,
Vancouver, BC

¹ Cole, D E C, and Lirenman, D S, *Pediatric Research*, 1977, 11, 548.

² Evans, G W, *Physiological Reviews*, 1973, 53, 535.

Allopurinol and urinary stones

SIR,—I read with interest your leading article on the use of allopurinol in urinary tract stone disease (19 November, p 1302). A male patient presented to this department in November 1976 with a stone impacted at the right ureteric orifice which required Dormia extraction. Analysis of this stone showed it to consist of calcium, urate, oxalate, and a trace of ammonia. He had previously passed a stone spontaneously, but as he neglected to retrieve it no information about its composition is available. He had no evidence of parathyroid disease. His blood and urine urate levels were normal.

In accordance with the protocol of a trial we are conducting in the department he was started on allopurinol 100 mg thrice daily. However, he formed another stone, which was removed by left upper ureterolithotomy in November 1976. Analysis of this stone showed that it consisted of calcium ammonium phosphate; neither urate nor oxalate could be detected. He is still on allopurinol and remains well and free from stone.

The patient is one of a group of subjects currently being studied with regard to the effects of allopurinol on urinary oxalate excretion. Most subjects within the group have shown a significant reduction in urinary oxalate values. It is interesting that in the case described there has been a change in stone composition and in particular that no oxalate has been found, although this is a common constituent of stones within this area.¹

P J PATERSON

Urological Department,
Royal Infirmary,
Glasgow

¹ Sutor, D J, and Wooley, S E, *British Journal of Urology*, 1971, 43, 268.

Crush injuries

SIR,—Your leading article on this subject (12 November, p 1244) states that "despite the advent of effective dialysis as treatment for post-traumatic oliguric renal failure, the overall mortality of 60-70% has not changed substantially from that reported 25 years ago."

In 1974 Flynn² reported the UK overall mortality for post-traumatic acute renal failure to be 50%. At Halton we have compared two periods, 1957-64 and 1965-75, with regard to mortality in trauma patients with acute renal failure. While mortality in the first period was 64%, this was reversed in the second period to 34%.^{2,3} The most important difference in management was the institution of daily dialysis, high-calorie feeding, and subsequently total parenteral nutrition in the latter group. Lordon⁴ talks about frequent dialysis in his patients (on whom your statistics are based) but then goes on to say that dialysis in those who died was once every 2-6 days.

He also states that improvement in parenteral nutrition might have been beneficial because of the marked catabolism in his patients. Adequate parenteral nutrition is not possible without daily dialysis because of the obligatory volumes required to provide the necessary calories and protein.

Control of catabolism and adequate dialysis will improve healing⁵ and reduce the susceptibility to sepsis.⁶ If early and adequate attention is paid to debridement and amputation, daily dialysis with total parenteral nutrition to control catabolism offers a much better prognosis than one might be led to believe from your article.

DAVID J RAINFORD

Renal Unit,
Princess Mary's Royal Air Force Hospital,
Halton,
Aylesbury, Bucks

¹ Flynn, C T, in *Acute Renal Failure*, ed C T Flynn. Lancaster, MTP, 1974.

² "Renal Problems in Trauma," Seminar, R N H Haslar, February 1977. Unpublished.

³ Rainford, D J, *Anaesthesia*, 1977, 32, 277.

⁴ Lordon, R E, and Burton, J R, *American Journal of Medicine*, 1972, 53, 137.

⁵ Teschan, P E, et al, *Annals of Internal Medicine*, 1960, 53, 992.

⁶ Parsons, F M, et al, *Lancet*, 1961, 1, 129.

IUCDs—a contraindication to removal

SIR,—I report here a case which shows that if an intrauterine contraceptive device (IUCD) is to be removed for reasons other than cessation of contraceptive measures it should not be removed at the time of expected ovulation.

A 32-year-old woman presented recently with six weeks' amenorrhoea and was found to be pregnant (last menstrual period 17 September 1977). She had had four previous pregnancies, all of which had been normal resulting in normal deliveries at full term, the children's ages spanning 8 to 2 years. She had had no serious illnesses in the past other than two episodes of pneumonia in the last three years, the last attack being in 1975. Investigations had not shown any underlying cause, though she was known to have a sensitivity to house dust which caused rhinorrhoea and occasional wheezing on exposure to dust.

For contraception in the past she had relied mostly on the vaginal diaphragm. Between her first and second pregnancies she had taken oral contraceptives, but these had caused unacceptable side effects and had been discontinued. Following the birth of her last child in November 1975 she again used a diaphragm, but when she had finished breast-feeding the infant, and on resumption of menstruation, she requested a change and in October 1976 she was fitted with a Gravigard Copper-7 IUCD. Her normal menstrual cycle came every 25-28 days, each period lasting six days with a moderate loss. Over the next few months her periods lengthened to 10 days and by September 1977 this had further extended to two weeks and it was decided that her IUCD should be removed. This was done on 30 September, whereupon she resumed the use of her diaphragm. She is a sensible and responsible person who had used this form of contraception successfully for some years previously, but despite this she presented five weeks later and was found to be pregnant.

Close questioning revealed that, although she had been scrupulous in observing contraceptive measures since the removal of the IUCD, she had had intercourse 48-72 h before this was done. Removal was effected 13 days after the first day of her last menstrual period and it therefore seemed likely that the IUCD had been removed just in time to allow implantation of a fertilised ovum. In view of all these circumstances she was referred to a consultant gynaecologist, who agreed to terminate the pregnancy.

Of course it is possible that this unfortunate sequence of events did not occur and that she

became pregnant simply because of failure of her diaphragm. Nevertheless, it is possible that it did occur in the manner suggested and this possibility should be borne in mind in future. In the large majority of women—that is, those with regular menstrual cycles—such an unwanted pregnancy can be avoided simply by ensuring that IUCDs are not removed during a time, say, seven days each side of midcycle. So far as I can tell from inquiries made so far this is not standard practice. I believe that there is a good case for observing this precaution in future.

D F E THALLON

Tring, Herts

Drug-related red-cell aplasia

SIR,—The interesting report by Drs G Reid and A C Patterson (3 December, p 1457) of a case of red-cell aplasia apparently due to gold therapy illustrates the difficulties encountered in identifying cause and effect in this and other marrow hypoplasias. Wintrobe¹ lists 13 drugs believed to cause red-cell aplasia, while another review includes 16.² In some instances the evidence rests on only a very few anecdotal reports. The situation is also confused by the fact that in some cases the patient's underlying disorder was one itself occasionally associated with red-cell aplasia. In the present case the patient had received at least two other drugs known to cause marrow depression and was suffering from rheumatoid arthritis, one of a spectrum of connective tissue disorders in which red-cell aplasia may occur,³ presumably on the basis of autoimmune disease.³ The suspicion that a particular drug is responsible is naturally increased when withdrawal of a single drug, any others being continued at their previous dosage, is followed by remission of anaemia, though for obvious reasons this is rarely, if ever, justifiable in practice. Yet another difficulty is the tendency of red-cell hypoplasia to remit spontaneously without treatment; indeed, it is possible that many cases go unrecognised unless the patient is under haematological surveillance.⁴

These diagnostic pitfalls are further illustrated in the following case, seen in this clinic. A man of 72 was referred by Dr R V Stone because of a history of anaemia of six weeks' duration. There was no history of exposure to drugs apart from chlorotrianisene (TACE), which the patient had taken for 10 years after a clinical diagnosis of carcinoma of the prostate, and prednisolone (40 mg/day), which had been given for a month after the onset of the anaemia. Clinical examination showed mucosal pallor and a moderately enlarged prostate but no other signs. There was no evidence of metastatic disease, and the blood creatinine concentration and serum acid phosphatase activity were normal. The blood count on 21 July 1977 was: haemoglobin 6.6 g/dl, leucocytes $13.5 \times 10^9/l$ ($13\,500/mm^3$) (neutrophils 84%), platelets $224 \times 10^9/l$ ($224\,000/mm^3$), reticulocytes 0.02%. Marrow aspiration confirmed profound red cell hypoplasia, granulopoiesis and thrombopoiesis being normal. Since high-dose oestrogen therapy may diminish erythropoietin production⁵ and there is a report of marrow depression in animals following prolonged oestrogen administration⁶ it was postulated that the patient's red cell aplasia was due to this therapy, which was stopped, as was the prednisolone, to which there had been no response. A blood transfusion was given. Further investigation showed that his serum contained a small quantity of paraprotein, identified as IgG-kappa type, but there was no other evidence of lymphoma or immunoproliferative disease and it was decided that his was an example of "benign monoclonal gammopathy."

Within three weeks of discontinuing all therapy his haemoglobin concentration began to rise and on 5 December was normal (14.7 g/dl), the patient remaining well.

Was this patient's pure red-cell aplasia due to prolonged oestrogen therapy, the first manifestation of an otherwise occult malignant disease, or simply an unrelated episode due, perhaps, to an unrecognised virus infection? It is impossible to decide at present, because the curious tendency of this type of marrow disorder to remit, sometimes for long periods,⁷ makes the role of external agents extremely difficult to evaluate.

COLIN G GEARY

University Department of
Clinical Haematology,
Royal Infirmary,
Manchester

¹ Wintrobe, M. M., *Clinical Hematology*, p 1769. Philadelphia, Lea and Febiger, 1974.

² Krantz, S. B., *Medical Clinics of North America*, 1976, 60, 945.

³ Case Records of the Massachusetts General Hospital, *New England Journal of Medicine*, 1973, 288, 729.

⁴ Linman, J. W., *Hematology*, p 434. London, Baillière Tindall, 1975.

⁵ Peschle, G., et al., *Endocrinology*, 1973, 92, 358.

⁶ Castrodale, D., *Endocrinology*, 1941, 29, 363.

⁷ Hirst, E., and Robertson, T. I., *Medicine*, 1967, 46, 225.

Clinical competence and the Ombudsman

SIR,—The Clwyd Local Medical Committee at a meeting on 11 December 1977 discussed the report of the Health Service Commissioner following the death of an elderly lady who had been treated at a Rhyl hospital. After discussion, it was unanimously resolved to issue the following statement:

"Clwyd Local Medical Committee, representing Clwyd general practitioners, has considered the report of the Ombudsman following the death of a lady of 103 years after travelling both ways between hospital and residential home at 11.15 pm and 2 am on a cold morning.

"For many years the public has ignored repeated warnings by the medical profession about the state of the Health Service. Deploable incidents are bound to increase as standards and morale fall in face of the progressive failure of Governments to provide adequate resources to meet rising demands.

"Clwyd Local Medical Committee strongly resents the attempt to use the Ombudsman system to steer criticism away from civil servants and politicians by denigrating the Health Service staff who are struggling to make the system work—the overseas doctors who keep the service afloat, the junior doctors with the unenviable task of preserving the capacity of a major accident unit to treat sudden acute emergencies.

"Fear of the Ombudsman and of legal criticism makes it very difficult for general practitioners to exercise humane discretion in sending very old people who fall immediately to hospital to exclude the possibility of fracture.

"This local medical committee has no confidence in the Ombudsman system. In courts of law evidence can be tested in public and an accused person has an opportunity to defend himself. Yet Sir Idwal Pugh was prepared to condemn the conduct of a Clwyd hospital doctor as 'inhuman' without obtaining or considering any explanation from him. In another case he investigated the conduct of the Clwyd FPC in the exercise of its functions under the National Health Service (Service

Committees and Tribunal) Regulations 1974 even though he is statute-barred from so doing. His decisions are based on evidence which, given in secret, cannot be challenged or tested by cross-examination. They follow no known legal principles or precedents. An act becomes right or wrong because he so decides rather than because a known rule or law was infringed. He is a civil servant, not a judge. He has a departmental rather than a judicial approach. Yet he has judicial powers.

"The rule of law is being replaced by the rule of civil servants, who have become both judge and jury and who, by manipulating statutory regulations past nominal parliamentary controls, can even write the laws of the land.

"Doctors don't run the country. Civil servants do. Blame them."

W E LEWIS

Secretary,

Clwyd Local Medical Committee

Mold, Clwyd

SIR,—We share everybody's unease about allowing the Ombudsman to investigate our clinical judgment, mostly because the informal way he proceeds must raise serious doubts about his impartiality. But this is tempered by our unshakable belief that nothing is served by evading criticism.

We do not share the attitude of our political representatives to this suggestion. They must be quite insensitive to the fact that the public might interpret their efforts as arrogant and secretive. To persist with this portrayal will more certainly harm doctors' relationships with their patients in the long term than any openness to criticism may do in the short term. Such a hostile response is inept. Perhaps the time is not yet ripe for doctors to function effectively without some of the old mystique, not least because we have too few doctors to cope with that situation. But we cannot go on in this way for ever. While perhaps defending the mystique, our representatives' opposition will certainly destroy the trust that alone can replace it. A doctor confident enough to welcome criticism will have patients confident in him. A doctor openly opposed to criticism cannot expect trust from anybody, least of all from the reforming zealots of a parliamentary select committee. The more they are opposed the more they will pursue.

There is indeed danger in the suggestions. Our fear is that our representatives, incensed by the questioning of their clinical authority, may fail to pay sufficient attention to the real dangers, which are procedural. That our clinical judgment must one day be openly criticised by laymen in public is inevitable. That it will be done impartially is not. Let us hope that our representatives appreciate this quickly. They would be wiser to be seen exploring, not opposing, these proposals.

PETER SOWERBY

W A BRIGHOUSE

Egton,
Whitby, N Yorks

New consultant contract

SIR,—You have kindly published letters from the National Health Service Consultants' Association in the past, though our policy on the consultant contract is different from that of your leading article (10 December, p 1502).

I hope you will feel able to publish this rather longer comment, because I agree with Mr R K Greenwood (p 1556) that "the profession [has] no idea what [is] in the new contract." In fact the paucity of debate on this extremely important issue in the pages of the medical press has been quite remarkable. It is obvious that there are major differences of opinion on the implications for the NHS and for individual consultants of the proposals of the Central Committee for Hospital Medical Services and I feel these should be spelled out.

There are two major differences between the CCHMS proposals and the current contract. The first is that the new contract will be work-load-sensitive. This will pose great problems for the administration and must surely lead to a much closer scrutiny by our employers of the way in which we actively use our time. None the less the principle seems fair.

The more important issue for us is the CCHMS's insistence on there being no "continuous commitment allowance"—that is, on losing the present two-elevenths differential to be made up by doing more work. We feel there are three major areas of disagreement on this point.

The first is the effect on whole-time consultants' salaries—those consultants who are unwilling or unable (because of specialty or geography) to develop a private practice. Here the interpretations seem totally opposed. You feel the differential will have increased slightly to two-tenths (by doing two-tenths more work—if it is available). We feel we have lost a bonus of two-elevenths. I strongly urge all whole-time consultants to read the proposals (p 1558) carefully and draw their own conclusions. If they do conclude that the salary/work load difference between whole-timers and part-timers will increase they can then ponder the implications for recruitment to those specialties and areas where a concomitant private practice is not a realistic option.

The second point is the effect on the NHS. This issue depends on whether the private sector is considered to be in competition with the NHS or merely complementary. It seems reasonable to suppose that were the NHS as good as we all wish it to be the demand for private medical care from the indigenous population would be negligible. The corollary is surely that deficiencies in the NHS will be reflected in a higher proportion of patients using the private sector. Dr E B Lewis (p 1555) comments that members of the armed Forces can do civilian jobs provided this does not interfere with their service commitment. I would suggest that this is a false analogy. If a soldier also runs a window-cleaning business the success of the latter will in no way depend on the efficiency of his army unit. I feel a more accurate analogy might be a manager of British Leyland working, in his spare time and on a commission basis, for Renault.

The third point is perhaps more philosophical, though no less important for that. The aim of the new contract is said to be to allow all consultants the freedom to do what they want in their free time. Yet if I freely decide that I wish to restrict what I do in this time and the DHSS is keen to pay me to do so—a freely entered into contract on my part—why should the CCHMS wish to deny me this freedom?

One final point. If, as you suggest, the average whole-timer working a five-day week will qualify for 12 NHDs while the average maximum part-timer, currently in theory